Patient's Name: _____

Date of Birth: _____ Patient's SS#: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Mother's Name: _____ SS#: _____

Employer: _____ Work Phone: _____

Father's Name _____ SS#: _____

Employer: _____ Work Phone: _____

Emergency Contact: _____ Phone #: _____

Primary Insurance: _____ Policy #: _____

Group #: _____ Policy Subscriber _____

Date of Birth of Subscriber: _____

I authorize the release of any information necessary to process an insurance claim, and authorize payment of medical benefits to Dr. Gary Halberstadt, D.O., for services rendered. I guarantee payment in full within 60 DAYS OF SERVICE, and that LATE CHARGES MAY BE ADDED to cover the costs of delinquent billings. Also, in the event of default in payment, I agree that reasonable costs of collection may be added to the amount due.

SIGNATURE: _____

DPT						
HIB						
IPV						
PNEUMOCOCCAL						
HBV						
MMR						
VARICELLA						
HAV						
MENINGOCOCCAL						
ROTA						
HPV						
FLUZONE						

ALLERGIES: